Policies/Procedures For Community Case Management

Section I

Legal Considerations

CLIENT RIGHTS

Assuring that a client's rights are protected is one of the most critical case management functions of BDS. Below is a list of case management tasks associated with safeguarding client rights.

Case managers are responsible for:

- Assuring that clients receive an explanation of their rights in understandable terms at intake.
- Assuring that the client's family or guardian receives an explanation of client rights and written materials, if desired,
- Assuring that providers of service to the client are familiar with the law,
- Monitoring the client's enjoyment of these rights through routine case management,
- Reporting any allegations of the denial of these rights to the Office of Advocacy or in the case of children, to the department of Human Services.

On the following two pages is a list of the rights of Maine citizens with Mental Retardation adopted from Title 34 - B of the Maine Revised Statutes Annotated, Chapter 186-A, intended as a guide to case managers when explaining there rights to clients.

THE RIGHTS OF MAINE CITIZENS WITH MENTAL RETARDATION

(This straightforward explanation of consumer rights, adapted from 34 - B MRSA Chapter 186-A, is intended for use by consumers and providers.)

I would like to tell you about the law that says how other people are supposed to treat you. This law says that you have the right to do certain things, and there are other things, which no one can make you do. For example:

- 1. No one can tease you or make fun of you. You can tell them to leave you alone if they do.
- 2. No one can stop you from going to church or saying prayers if you want to.
- 3. No one can read your mail unless you say it's O.K. No one can stop you from mailing a letter.
- 4. No one can stop you from using the telephone, TTY or fax machine and no one can listen to your phone calls unless you say it's O.K.
- 5. No one can stop other people from coming to visit you, and no one can hang around when you have company unless you say it's O.K.
- 6. If you have a job, you have to be paid fairly according to existing laws. You can ask your case manager for details.
- 7. No one can stop you from voting, and no one can tell you who to vote for. After you vote, no one can make you tell who you voted for unless you want to tell.
- 8. No one can take away your clothes or money, or touch any of your things unless you say it's O.K.
- 9. No one can take away your food to punish you or to be mean to you.
- 10. No one can stop you from going to the doctor if you don't feel well or to the dentist if your teeth hurt. No one can stop you from asking the doctor to come see you if you don't have a way to get to his/her office. If you want to see the doctor or dentist, just ask. No one can make you go the doctor or dentist if you don't want to go.
- 11. No one can make you take medicine to punish you or just to keep you quiet or sleepy.
- 12. No one can stop you from talking to other people.

- 13. No one can stop you from going outside to walk around or going to the movies or things like that.
- 14. Nobody can hit you or hurt you for doing something wrong.
- 15. No one can hold on to you against your will unless they are sure you are going to hurt yourself or someone else. No one can hold you against your will just to punish you or be mean to you.
- 16. No one can put you in a bed with bars on it unless it is to protect you from falling out.
- 17. You have a right to see anything that is written about you. All you have to do is ask. No one can show these records to anybody unless you say they can.
- 18. You have the right to get together with the other people you live with and to form a group to make your needs known to those who own and run the place you live and work in.
- 19. Before anyone can put you in an institution such as Bangor Mental Health or the Augusta Mental Health Institute they have to prove to a judge that you need to go to an institution, and that an institution is the best and only place for you at the time.
- 20. If you think someone is trying to stop you from doing any of these things or isn't treating you the way they are supposed to, you can tell your case manager or someone who is your friend to help you make them stop treating you wrong.
- 21. No once can talk about you to others without your permission.
- 22. If you use sign language or gestures to communicate, you have the right to work, live and relax with other people who can sign to you and can understand your signs and gestures.

GRIEVANCE AND APPEAL

It is the policy of BDS to ensure that needed services are provided to persons with mental retardation in accordance with the laws of Maine, to the extent resources permit. Further it is the policy of BDS to provide for review of a decision in which a person is denied a service.

All persons and/or their representative who are eligible for services shall have the right to appeal any action or inaction of BDS related to or involving rights afforded by state or federal law, Departmental rules, regulations or policies. Consumers of services shall be notified annually that they have the right to appeal any action or inaction.

The Mental Retardation Services GRIEVANCE AND APPEAL PROCESS is an established policy and can be obtained from any of the Regional Offices in policy or brochure. The brochure was produced for consumers and families and states clearly in plain language how to process an appeal.

LEGAL CONSIDERATIONS

A number of protections have been afforded our clients through the laws of the State of Maine. This section of the Manual describes DMHMRSAS practices in carrying out its legal mandates.

The Laws that you, as a case manager, should be familiar with are:

34 B MRS. subsection 5431 et. seq.	Community-Based Services for Mentally Retarded Persons
34 B MRS. subsection 5601 et. seq. 34 B MRSA subsection 5461 et. seq.	Rights of Mentally Retarded Persons. Process for Provision of Mental Retardation Services
34 B MRSA subsection 5002 et. seq. 22 MRSA subsection 3470	Declaration of State Policy The Protection of Incapacitated and Dependent Adults
34 B MRSA subsection 5474-7 34 B MRSA subsection 7001 34 B MRSA subsection 5477 34 B MRSA subsection 5475 34 B MRSA sub section 1218	Involuntary Admission Sterilization Emergency Procedures for Admission Judicial certification Accessibility to MR for Persons who are Deaf or Hard of Hearing

Marriage

34 MRSA subsection 1207 Law on Disclosure of Client Information

18 A MRSA subsection 5-601 Guardianship

All of these laws are available at each Department Regional Office or can be accessed through the State of Maine Home Page.

STERILIZATION

In 1982 the Legislature passed a law entitled "Due Process in Sterilization Act of 1982". See 34 B MRSA Subsections 7001-7016. The Legislature, recognizing the irreversible nature of sterilization, intended "to prevent discrimination and unnecessary sterilization, and to assure equal access to desired medical procedures for all Maine citizens.

The law currently requires that the person requesting sterilization give to a physician their "informed consent". Informed consent is based on an actual understanding of the nature and consequences of sterilization, its risks and benefits, and an understanding of the alternative methods of contraception. There must be neither expressed nor implied coercion in giving such consent. A due process hearing in Maine District Court is necessary to determine a person's ability to give informed consent, if the person is under 18 years of age and not married, or a resident of a state institution providing their care, or under public or private guardianship, or someone from whom the physician could not obtain informed consent.

Finally, if there is any chance that sterilization may be seriously pursued; the case must be discussed with (at a minimum) the MR Team Leader and an AAG. Individual Support Coordinators should not become involved in explaining legal requirements to parents, clients or guardians. Sterilization requests should be referred to the client's guardian. If the guardian is the one requesting information on a ward's sterilization, the ISC should recommend that the guardian discuss the matter with an attorney. Sterilization of a client is a legal matter and can only be resolved by the courts.

Section II Case Management Procedures

ACTION PLAN PROCEDURES

Person-Centered Planning is a process that assists and supports each person in creating a vision for how to live in and be a part of the community. Through the pre-planning and planning process, the planning team works with the person to articulate and identify specific Needs and Desires within the larger framework of the person's vision for the future. All Needs and Desires shall be addressed in Action Plans in accordance with the following procedures.

- 1. A "Need" is something identified by the consumer/guardian and the team that is required to maintain or improve a person's quality of life and should to be met within a specific time frame. Examples are housing, employment, day services, medical and other professional services, respite, leisure, family support, transportation.²
- 2. A "Desire" is anything else the person wishes to achieve/have/obtain, which is not a Need. Whether a goal is categorized as a Need or a Desire will, at times, depend on the person's circumstances. A Desire for one individual may be a Need for another person.
- 3. The team with the consumer/guardian leading is responsible for deciding what is identified as a Need, and what is identified as a Desire. These determinations are not final and irrevocable and what is identified initially as a Desire may, with a change in circumstances, later be reclassified as a Need. In this process, the team should be mindful that the person drives Person-Centered Planning.
- 4. Once identified and articulated, all Needs and Desires shall be recorded in the Person-Centered Plan without regard to whether they are reasonably achievable or presently capable of being addressed.
- 5. All Needs and Desires must then be recorded in an Action Plan attached to the Person-Centered Plan. Within the Action Plan the team must identify the following: 1) specific action steps required to meet the Need or Desire; 2) time frames for each action step, for reporting on progress, and for ultimately meeting the Need or Desire; and 3) persons responsible for action steps and reporting. The team shall monitor the

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¹ See Person Centered Planning Preparation/Procedure Guide (5/30/01); Implementation and Facilitation Manual for Person Centered Planning (May, 1996); and Planning with People (Feb. 1995).

^{2.} For Class Members, a Need includes any service or circumstance that the Department is obligated to provide under the Consent Decree.

person's Needs and Desires on an ongoing basis in accordance with the Action Plan. Desires will be addressed in the Action Plan process in the same manner as Needs except as stated in paragraph 8 below.

- 6. It is expected that, when the required resources are available to the team, most Needs shall be met within 90 days. It is also understood that for some Needs, such as housing and employment, a time frame of 90 days or less may be unrealistic even when all required resources are available to the team. Whenever the team identifies a time frame greater than 90 days, it must provide an explanation in the Action Plan for why the Need cannot be met within 90 days despite the availability of all necessary resources. Time frames may be adjusted only when necessary due to the consumer's inability or unwillingness to participate.
- 7. A Need will be identified and treated as an "Unmet Need" when it has not been met within the time frame set by the team or whenever the team has determined, at any point in the process, that a resource required to address the Need is not available.
- 8. Once an Unmet Need is identified, the team must prepare an Interimed Plan for providing services and supports that come as close as possible to meeting the Need in the interimed while the team pursues the required resources for meeting the actual, identified Need. Within the Interimed Plan, the team must identify action steps, time frames, and persons responsible for action steps and reporting. The Interimed Plan becomes an adjunct to the Action Plan.

The team is obligated to conduct interim planning for Desires within the Action Plan. If the team determines that a resource required to address a Desire is not available, the team must develop action steps within the Action Plan that address the Desire as nearly as possible in the interim while the team pursues the unavailable resource.³

9. The format of the Action Plan will be consistent statewide and will incorporate the procedure outlined above. The Action Plan will be submitted to the regional office with the Person-Centered Plan and the

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³ How and whether Desires are to be addressed in Interim Plans (sometimes referred to as "Bridge Plans") has been a matter of some confusion and inconsistent treatment in Department training materials. With respect to Class Members, the Consent Decree states that the team shall develop interim plans that address Needs *or* Desires as nearly as possible. *Decree, Article VII.1*. The Decree also requires certain record keeping for Unmet Needs but not "unmet desires." "Interim Plan" documents will now be used for Needs and *not* Desires to facilitate accurate record-keeping of Unmet Needs and the resources required to meet them. The obligation to conduct "interim planning" for Desires will, however, be performed within the Action Plan process.

Plan data will be entered into the E.I.S. system upon approval of the Plan. (See Person Centered Planning Preparation/Procedure Guide 5/30/01). This will allow ISCs, teams and other interested parties to track Needs, Desires, Unmet Needs, unavailable resources, the identity of responsible persons, time frames, and other Action Plan information. There will also be a "tickler system" within EIS for case management tracking of Needs and Desires, as well as a case note field for updating the Person-Centered Plan.

These guidelines are designed to empower the team in supporting the person regarding Needs and Desires. Person-Centered Planning is driven by the person or the person's guardian. The person and/or guardian provide the direction to the team. Other members of the team provide input, support, and guidance to the person regarding Needs and Desires and the planning process in general. If there are divisions between the person and team members, then the person's request should be honored to the extent possible except for reasons of health or safety. Team members always have the choice to not support the conclusions of the team by not signing the Plan. If there is a division between the person and the guardian or family members that cannot be resolved then mediation support is a suggested way of attaining resolution. When team members cannot reach consensus on an issue and the person or guardian has not expressed a preference on the matter, a majority vote of team members will control.

If a person or the person's guardian is dissatisfied with any part of the Plan or the planning process, they have the right to appeal in accordance with the Department's appeal procedures. The person or guardian may obtain assistance from the Office of Advocacy to file or pursue the appeal.

The Individual Support Coordinator shall be responsible for ensuring that the Person-Centered Planning process is conducted in accordance with these procedures and shall be responsible for monitoring the planning process in accordance with the Case Management Manual and the Consent Decree. Active Status for Case Management

ACTIVE CASE MANAGEMENT

Active status for case management includes people who have been found eligible for Mental Retardation Services and need a case management services as defined below. This determination, made by a Mental Retardation Services Case Management Supervisor is a result of an assessment of their needs through the intake process or through the procedure for Transfer of Case Status. The person may be assigned to inactive or closed status if they meet the criteria. This determination can be made at the conclusion of the eligibility process.

Case Management Services includes the following:

- A. Assessment of the persons medical, social, educational, and other needs. This intake process will include the review of the results of the psychological evaluation; developmental and biographical history, behaviors, traits, and qualities; the persons current circumstances; the resources, services and accommodations provided to the person; the persons significant relationships, problems, requirements, and needs. (This is the responsibility of Mental Retardation Services. Is not performed by Community Case Management.)
- B. Development and implementation of a Service Plan under the direction of the person and in accordance with the policies of BDS.
- C. Coordination of the service providers and resources identified in the Service Plan.
- D. Linkage of the person with appropriate agencies, community resources and informal support systems, including referral to transportation services.
- E. Monitoring the person's progress toward the achievement of objectives specified in the Service Plan. The plan will be reevaluated as often as is specified in the plan. The individual support coordinators will evaluate the person's status and needs periodically and implement changes in the plan of care, as necessary.
- F. Appointment of the State of Maine as legal guardian.
- G. Health and Safety needs that require the support and protection of the person by Mental Retardation Services.

CASE MANAGEMENT ACTION NOTE PROCEDURE

Case Managers are expected to maintain regular consumer contacts, and to maintain regular action notes. Both contacts and action notes should be in accordance with the needs of the person as identified in the person-centered plan.

Contacts should occur often enough to assure that Case Manager remains appraised of the consumer's **safety** and well being, as well as maintaining familiarity with any providers who are serving the consumer. Whenever applicable, the Case Manager should arrange his contacts so that s/he visits the consumer in the full range of settings in which the consumer lives, works, and socializes.

Face-to-face contacts are preferred. Other acceptable contacts may include phone conversations, written contacts, e-mail, if scheduling conflicts prevent a direct visit, or if the consumer does not wish to have direct contact with the Case Manager. In either of these cases, the Case Manager's action note for the month should reflect this fact.

Notes should:

- Monitor the status of action plans and service needs as indicated in the annual planning process
- Reflect any contact (personal or phone)
- Record events surrounding quality of life areas (i.e. Health and Safety, Home, Vocational, Rights, Choice, Relationships)
- Changes in medical and dental condition (medication, allergies, etc)
- What actions have taken place
- What actions need to take place
- Sequence of notes reflects the level and quality of supports and services an individual is receiving

When writing Action Notes, the following information should be included:

- Signature and date
- Place of contact (residence, vocational, etc.)
- Type of contact and who was present (face to face, telephone, collateral, etc.)
- State issue
- State observation
- State action
- State follow-up

Action Notes should be prepared as soon as possible after the contact; in any case, within 10 workdays.

Community Case Management Transfer Policy

Purpose- The purpose of this policy is to provide guidelines in the transfer of case management services when due to consumer choice of another provider, a conflict of interest necessitating a change in provider, or the need for state case management.

Procedure

- If a consumer/guardian chooses to change case management services the
 providing agency will assist the consumer/guardian in identifying other potential
 providers and share pertinent information with releases. The transfer of case
 management responsibilities will be under the direction of the consumer/guardian.
 It is suggested that a transfer meeting occur with the person and the agencies
 involved. A transfer date will be identified. Case Management billing can only
 occur once within a month, and cannot be billed by two agencies providing <u>adult</u>
 case management services within the same month.
- 2. If a consumer chooses another contracted service from the agency providing case management services (i.e. day habilitation) they must transfer to another agency for their case management services. This transfer will need to take place as soon as possible, but no later than 90 days from the start date of the other contracted service being provided. Within that time period, the agency will be able to bill for the case management service.
- 3. People receiving case management under Children's Services can transition to adult services between the ages of 18-21. The person must be found eligible for Adult Mental Retardation Services and can do so starting at age 18. When the person/guardian decides to transition to adult service case management the Children's Services case manager can assist the person in remaining with that agency if it provides adult services or seek an alternative. The person/guardian can also contact Mental Retardation Services for assistance in linking to a provider. A transition meeting will need to occur with the person and the case management agencies. Billing can occur for one-month overlap between Children's and Adult case management to support the transition.
- 4. If a person needs to transition to state case management the community case manager will work with their supervisor and the regional office of Mental Retardation Services to transition the person to state case management. The procedures for transfer outlined in #1 will be followed.

CONSUMER FILES/RECORD KEEPING

Keeping an accurate and current account of significant events in a persons life, services provided. and evaluations performed are extremely important. Good record keeping can greatly enhance the continuity of case management services by accurately reflecting that the needs and desires of people we support are the focal point of all services requested and provided. In addition it provides the basis for quality assurance and oversight. The case record should include, but is not limited to, the following;

- 1. Demographic information.
- 2. Copies of the most recent and pertinent evaluations (i.e.; psychological, psychiatric, O.T., P.T., Speech, etc.).
- 3. Medical and dental information. Indicate where primary medical information is (i.e.: residential file at supporting agency).
- 4. Copies of the individual's annual plan.
- 5. Action notes should accurately reflect any 'contacts' that have been made in regard to each individual/significant events that have occurred, and what actions have taken place, or need to be taken, around those events. Would this information be helpful to a future caseworker/is it pertinent for effective service delivery?
- 6. Events that should trigger an action note would be:

Significant events in the person's life (i.e., job/daily activity changes, medical, family, legal, protective, etc.).

Status of action plans and service needs as indicated in the annual planning process Phone contacts with the consumer or provider that yield some resulting action. Personal contacts (i.e., home or job visit) that yield some insight into the person's quality of life, what the individual wants, etc.

- 7. Guardianship information
- 8. Evidence of any legal/judicial involvement
- 9. Correspondence
- 10. Copy of mortuary trust/funeral arrangements, if any
- 11. Quality assurance/consumer satisfaction information
- 12. Information on best method for communication, preferred interpreter, or where to locate a "dictionary of communicative intent" for individuals with unique communications styles.
- 13. If the consumer is deaf, non verbal and signs or is familiar with another spoken language the name and contact information regarding a qualified interpreter or individual who is familiar with the consumer's communication style.

Consumer/Community Support Coordinator

One of the primary roles is to assist and support the consumer in planning his/her life. The Community Support Coordinator needs to assure each consumer receives an opportunity to participate in personal planning. Community Support Coordinators enjoy a very unique relationship with consumers, a relationship that is in large part determined by the persons personal vision for a desired life. For some consumers, the relationship needs to be supportive and non-directive, for others the Coordinator needs to assert more responsibility. The foundation of relationships between the Coordinator and consumers lies in the role of assisting to reach the persons vision for a desired life and monitoring the quality of life. Monitoring is done through personal contact and phone calls to the consumer, his/her family, and involved support staff. The frequency of this contact is determined by the consumer need, request, problems, type of program and the personal planning process.

Contacts with consumers should occur in the home, work, and community. Often, there are different issues for the person in each environment.

During the course of the individual support coordinators contact with the consumer, attention needs to be paid to the consumer's:

- 1. Programming/work needs
- 2. Physical well-being
- 3. Emotional well-being
- 4. Social well-being
- 5. Environment (home & work)
- 6. Communication with staff, family and peers

Additionally, it is important for the Individual Support Coordinator to develop positive relationships with the consumer's primary support staff, family and guardian. This will facilitate good communications to support the consumer's well being.

DEAF SERVICES

Services provided by the department will be designed and implemented to meet the needs of individuals who are deaf, hard of hearing, or hearing/non-verbal signing. This will include the following services or activities:

- Appropriate assessments to determine an individual's hearing level and preferred mode of communication will be held. Individuals who are deaf, hard of hearing or who have neurological or physical damage precluding the acquisition of speech shall be taught sign language or an alternative communication system.
- 2. At appropriate intervals individuals will be reassessed to determine changes in hearing level or need for alternative forms of communication.
- Individuals whose preferred form of communication is American Sign Language or other signing/visual gestural system will have a qualified interpreter available for any meeting involving the individual and staff of the department.
- 4. Each Regional Office and major sub-office shall retain the services of at least one case manager who is fluent in American Sign Language and other manual communication modes and knowledgeable about deaf culture and who will be responsible for coordinating services to individuals who are deaf or hard of hearing in that region.
- 5. Appropriate environmental modifications including intensive sign language training to staff and client peers will be made in all residential facilities and day programs where individuals are deaf or hard of hearing.
- 6. Families, housemates and neighbors of individuals who are deaf or hard of hearing will be offered training in the alternative communication form used by their family member who is served by this department.
- 7. At each person centered planning meeting involving an individual who is deaf or hard of hearing appropriate plans will be made to work on the communication needs of that individual and his/her supports. Case managers must ensure that plans developed are monitored regularly to ensure appropriate follow through.
- 8. The department will work with providers in order to ensure that staff that work with individuals who are deaf or hard of hearing have qualified staff to work with them, including appropriate qualifications or training in the form of communication used by the individual.

Discontinuation of Community Case Management

Discontinuation of Community Case Management may occur for several reasons including:

- 1. The needs of the individual no longer meet the criteria of active case management. (Refer to active case management in procedure manual).
- 2. The needs of the individual exceed the roles and responsibilities of a community case manager. (Examples include needing waiver level of services, needing public guardianship.)
- 3. The person moves from the area or the state.
- 4. The person chooses to leave the organization that they receive case management services from.

1. In the event that case management considered to be no longer needed this would be identified in the persons plan and would be referred to a regional Supervisor for review for inactive status and the following procedures would occur.

Inactive case management status assigned to people who have been found eligible for Mental Retardation Services, receive services from the department, (ex. Day hab, respite, family support) but do not require case management services at the present time because there is a reliable history of natural supports providing the case management functions. A Mental Retardation Case Management Supervisor makes the determination.

The following describe some situations in which inactive case management may be appropriate:

- No legal involvement or if there is a legal issue the person has an attorney representing them.
- Not a class member
- A class member who has refused case management services. If annual follow-up is refused case will be placed in closed status.
- Not under public guardianship
- Assistance in managing financial issues is not needed or assistance is available
- Routine health care that is arranged without the assistance of a case manager.
- Program/work/housing are stable
- Healthy relationships with family, friends, natural supports
- No planning needed or receives from another source such as day program or housing
- Representative Payee someone outside the Department provides Service.

Monitoring of Inactive Case Management Status

Each Regional Office will ensure the monitoring of people in inactive case management status. This may be done through a contracted service or by assigning a staff person other than an Individual Support Coordinator with an active caseload. Monitoring will include at least an annual face-to-face contact with each consumer unless the consumer specifically requests not to be contacted. All such request will be documented. All contacts will be documented in the file. In addition a letter will be sent annually asking the if they are satisfied with the degree and scope of services being provided as well as reviewing their rights, review of the grievance and appeal process, and access to the Office of Advocacy. This letter will identify the regional contact person. The Regional Office will ensure that:

- There are timely responses to requests made by individuals in this status
- Assistance in connecting individuals with services in their community is provided when needed.
- There is adequate monitoring of the level of need and recommendations made to the Case Work Supervisor regarding the need for a change is case management status. (See case status change procedure.)
- 2. If the needs of the person exceed what the community case manager can provide those needs have to be identified in the person centered planning process. A review of the case would occur between the community case managers supervisor and the liaison for Mental Retardation Services as well as a Regional Supervisor for Mental Retardation Services. A determination will be made within 30 days of the request for review as to whether case management should be transferred to State case management.
- 3. If the person is moving to another area of the state resulting in the need to change the community case manager/agency it is the responsibility of the case manager to facilitate that transfer by identifying potential providers of the service in the area and arranging for interviews by the person/family. It is also the responsibility for the case manager to inform the local BDS office as well as the office in the region the person is moving to.

If the person is moving out of state it is the responsibility of the case manager to assist in connecting to potential service providers in the state the person is moving to if requested by the person/guardian as well as providing notice to the BDS office as soon as the case manager is informed. When case management ends, presumably when the person leaves the state, the case should be closed. (See Closed Status for Case Management)

4. If a person request a change in case manager or agency it is the responsibility of the person and their family to give a 30-day notice to the case manager. It is then the responsibility of the case manager to assist the person /family to identify a new service.

FAMILY SUPPORT POLICY

1. Purpose and Scope.

The Family Support Program provides financial assistance to the extent that resources permit to families who have adult family members with mental retardation or autism living with them.

The goal of the program is to provide the needed level of support in order to maintain the unity of the family and to support the family's desires and preferences for services within BDS ability to meet all or some of those needs depending upon the availability of resources.

2. <u>Authority</u>: 34-B M.R.S.A. 5003

3. Procedures.

DMHMRSAS may reimburse eligible family members for services in instances where Mental Retardation Services would have agreed to pay a non-family member to deliver the service.

Family support includes a variety of services. Examples of family services include, but are not limited to, the following: respite care services, summer camp, recreation opportunities, transportation, after school care and arts and crafts.

Expenditures for family support services requires prior approval from the Regional Office.

Families who qualify for the Family Support Program can bill DMHMRSAS either before or after the service is received. Funds will be paid directly to the family as reimbursement for the service or directly to the service provider.

FUNDING REQUESTS ON OPEN ACCOUNTS

Funding requests for funds from open accounts may originate from the consumer or from some other member of the consumer's planning team; further, such requests may be directed at a broad spectrum of services and purchases. In all cases, however, they must meet these criteria.

First, they must be directed at an overall goal of increased independence, capacity building, or a therapeutic goal. These goals must be identified in the Person Centered Plan, or in some other supporting document.

Second, they must either be directed at a health or safety concern, clearly identified; or, in the case of recreational and social goals, they must be integrated into the plan in some fashion. For example, a consumer may request funding supports for a consumer to go on an excursion or a vacation. However, approval of funds for such purposes will be predicated upon the consumer's involvement in saving for or otherwise contributing to the achievement of the goal—in other words, approval is based upon the activity having some habilitative or learning value.

Third, supervisors must in all cases review and approve requests prior to sending them to the Finance Team. Supervisors will be more or less aggressive in prioritizing requests, depending upon the funds remaining available in the accounts.

Family Support Funds (see the relevant policy) are predicated upon the assumption that the receiving family may exercise broad discretion in utilizing such funds, and thus are not subject to the justifications listed above.

MEDICAL SERVICES

It is the case manager's responsibility to monitor the consumer's access to medical and dental services. For consumers who live with their families, the case manager may need to assist the family in locating a physician or dentist. Generally, the family will assume responsibility for making appointments and providing transportation.

The case manager needs to maintain records, copies of reports, etc. regarding the consumer's medical condition. The case manager needs to know who the primary physician is, and the status of any acute or chronic medical problems. The case manager communicates this information to persons involved with the consumer who "need to know" the consumer's medical condition.

For most consumers, either medicaid or medicare will reimburse medical expenses. Certain medical services and supplies can only be received with prior authorization from the Division of Medical Claims Review, Department of Human Services (289-3081). Rules covering medical

services and reimbursement can be located in the Maine Medical Assistance Manual.

Dental services are generally not reimbursable, except for children.

MORTUARY TRUSTS

When individual consumers have assets that may offset their eligibility or continued eligibility for SSI and/or Medicaid Benefits it may be appropriate and prudent to consider a Pre-arranged and Pre-financed funeral arrangement, better known as a (Mortuary Trust Fund), as a means of protecting those assets. As these assets are considered to be assets of the Trust not the individual they are protected when qualifying for SSI and/or Medicaid.

A Mortuary Trust Agreement is an irrevocable written agreement between an individual or their guardian, the (Donor), and a Funeral Home which becomes the TRUSTEE for that trust, that authorizes the funeral home to establish an interest bearing account to cover the costs of funeral services upon the death of the individual named as recipient of the trust. All funds received by the Funeral Home and all interest that accumulates in the account can only be withdrawn upon the death of the individual named by the trust.

Depending on the specific circumstances, such as the age and health of the individual, \$1,400 to \$2,000 would be a reasonable amount to set aside in a Mortuary Trust and may be endowed either as a single deposit or on installments.

The following procedure is suggested when establishing a Mortuary Trust Fund:

- 1. Where appropriate, potential arrangements should be discussed with the individual and his/her family members and their wishes should be incorporated into the plan. This should include choice of funeral home, burial site and type of service.
- 2. Contact the funeral home to develop the specific Trust agreement that should include a clause requiring the home to advise the individual of the discontinuation of the trust or transfer to a different Funeral Home.
- 3. The Trust Agreement needs to contain at least the following provisions:
 - a. that the Trust is irrevocable.
 - b. The specific services to be provided.
 - c. The name of the Financial Institution where the proceeds an interest of Trust will be maintained.

PERSONAL PLANNING POLICY

- A. Community Support Coordinators will plan with individuals for the coordination and delivery of supportive and other services through the development of a personal plan. The type of plan, participants and agenda at the planning meeting will be selected by the individual and/or their guardian. (CSC's have to receive the curriculum training for Person Centered Planning prior to doing planning with people they support.)
- B. The personal planning process will be:
 - 1. Understandable and in plain language or if the individual is deaf, non-verbal, signing, or speaks another language; the process will include qualified interpreters.
 - 2. Focused on the person's choice
 - 3. Reflective of and supportive of the person's goals and aspirations
 - 4. Developed at the direction of the consumer and include people the consumer chooses
 - 5. Flexible enough to change as new opportunities arise
 - 6. Reviewed according to a specified schedule and by a person designated for monitoring
 - 7. Inclusive of the needs and desires of the person without respect to whether those desires are reasonably achievable or the needs are presently capable of being addressed
 - 8. Inclusive of a provision for assuring each person's satisfaction with the quality of the plan and the supports he/she receives
 - C. The plan will focus on the supports identified by the individual.
 - D. The plan will be written and approved by the consumer/guardian within thirty (30) days of the meeting date.
 - E. The plan may be facilitated by the consumer, the Community Support Coordinator, other agencies providing major services to the individual, family members or other persons chosen by the consumer.
 - F. It is the responsibility of the Community Support Coordinator to assure that the person centered plan is written and that the action plan is entered in EIS.

RELEASE OF INFORMATION

I. PURPOSE

The purpose of this information is to insure the confidentiality of all written records or accounts in accordance with state and federal statutes and regulations. An effective confidentiality procedure should result in the protection of the dignity and privacy, rights and interest of the individual client and his/her family. As a general principle, the client and his/her legal representative has the right to decide what personal information may be released, to whom and for what purpose. Generally, a person requesting information should demonstrate clearly that the requested information will serve a specific purpose associated with the needs of the client. Case managers should refer to their regional office for a copy of the Maine State law on Disclosure of Client Information.

II. OBTAINING INFORMATION FROM ANOTHER AGENCY OR INDIVIDUAL

There must be a release of information form, signed by the client, if legally competent, or the client's legal guardian, in order to obtain information about the client. In obtaining information from another agency or individual, inquiry should be made as to the agency/individual policy regarding release of information. the agency/individual policy should be honored insofar as possible in DMHMRSAS utilization of the information.

III. RELEASE OF INFORMATION TO ANOTHER AGENCY OR INDIVIDUAL

There must be a release of information form, signed by the client, if legally competent, or by the client's legal guardian, in order to release any information about the client. In releasing information, the DMHMRSAS worker must make sure that the information is stamped as being privileged and confidential. the release of information shall specify the information released. There must also be a clear notation in the case record indicating the information released and the circumstances of the release.

IV. CLIENT/LEGALLY AUTHORIZED PARTY ACCESS

- A. <u>General:</u> Clients, former clients, or other legally authorized parties may examine the entire client record, if the request is submitted to the regional office/facility. In order to avoid misinterpretation of record content, a professional staff person should be available to answer questions at the time of the record review. The client or legally authorized party <u>may</u> obtain copies of any or all parts of the record and may be charged a reasonable cost for such reproduction.
- **B.** Exceptions: There may be situations where information contained in the client record may be deemed by a professional as harmful to the client or his/her family. Discretion shall be used in the disclosure of this type of information. Discretion must also be used in releasing information regarding

an adult protective investigation, e.g., 22 MRSA Section 3474 subsection 2, Optional Disclosure of Records.

V. FAMILY RELATIVE, FRIENDS (other than legally authorized party) ACCESS

When a client or legally authorized party gives written consent to have specific record or type of record released to a specific person on a routine basis, such information shall be released routinely.

VI. EMERGENCY TREATMENT

In emergency situations, information about the client may be released without a signed release of information in order to secure the emergency treatment needed, e.g., medical emergency, emergency placement.

VII. TRANSFER OF INFORMATION WITHIN THE DEPARTMENT

The transfer of client information interdepartmentally within DMHMRSAS may occur when a) there is a clear need for the information transfer; b) the case record is properly noted regarding the transfer; and c) the material is clearly marked confidential. No release is needed.

VIII. AGENCIES AND INDIVIDUALS SERVING MR SERVICES CLIENTS

An individual or an agency should be permitted access to client files in the absence of either the client's informed written consent or a court order, only to the extent that disclosure of information is "necessary to carry out any of the statutory functions of the department", 34B MRSA, Section 1207, subsection 1B. If the individual or agency is, by contract or other agreement, performing a function on behalf of DMHMRSAS for its clients, access to whatever information is needed to carry out that function should be granted. Some statutory functions of DMHMRSAS are specified in Maine law: assessment of need to develop a prescriptive program plan, 34 B MRSA Section 5462; execution and performance of service agreements, subsection 5471; provision of protective and support services, Section 5203; provision of residential, educational training services to wards of DMHMRSAS, 18 MRSA subsection 3628. The range of services which are required to fulfill DMHMRSAS's obligations will vary from client to client and from case to case, as will the scope of disclosure which is necessary to carry out those obligations. Individuals and agencies seeking access to files in the control of DMHMRSAS, as a threshold, must be working on behalf of the client at the request of DMHMRSAS.

IX. COURT ORDER

An order of the court shall cause the institution/regional office to disclose information to the extent required by the order. A copy of any such legal order shall be kept on file in the client's record. Any question regarding the validity or interpretation of the court order shall be referred to the Attorney General's Office for resolution.

X. EDUCATION/RESEARCH

Permission may be given for students or researchers to view specific types of information, based on a written request. Approval may be given by the Program Manager for Mental Retardation.

XI. ASSESSING ABILITY TO GIVE INFORMED CONSENT

There will be situations where a client's ability to give informed consent may be in question. A psychologist an advocate and interpreter, if needed; should participate in any assessment of a client's ability to give informed consent.

XII. CONFIDENTIALITY WITH LEGISLATORS

From time to time legislators become involved with individual client situations and will ask for information. In these cases, the same release of information provisions would apply to a legislator, as to any person seeking client information. Department statutes set out these circumstances under which information can be released. These are:

- 1. With consent of the client or legal guardian,
- 2. As necessary to carry out the functions of the Department,
- 3. By Court order.

As with any person, an explanation of our confidentiality statutes and the importance of protecting the privacy of clients should be given. It is also important to offer to assist the legislator in obtaining necessary releases.

XIII. Questions

You should always seek the advice of other experienced case managers or your supervisor whenever there is <u>any</u> question about confidentiality. Case managers and supervisors should also not hesitate to consult the Attorney General's office and ask for a legal opinion regarding confidentiality. The AAG's Office can be reached at (207-626-8800) TTY (207-626-8865).

Section III Medical

ADAPTIVE EQUIPMENT

The goal of the Adaptive Equipment Program is to provide information, consultation and/or adaptive devices in order to supplement habilitative services and improve the quality of life of the individual.

The Adaptive Equipment Program is located in Lewiston and is staffed by a registered, licensed physical therapist, a carpenter and an upholsterer.

Services available are the following:

- 1. Consultation to therapists, physicians, classroom teachers, residential staff, etc., to provide a clear understanding of the special equipment needs of the individual.
- 2. Information concerning the availability of commercial and 'recycled' equipment. Designs may be provided to persons who wish to construct equipment themselves.
- 3. The design and construction of adaptive devices that are therapeutically correct, sturdy, attractive and reasonably priced.

Services are available to persons with developmental disabilities. The individual may or **may not** be a client of DMHMRSAS.

Further information may be obtained by contacting:

Pam Woodhead Region 2L Mental Retardation Services 200 Main Street Lewiston, Me 04240 Tel (207)795-4500 or TTY (207)795-4503

A TTY or fax machine, closed captioned television, flashing/vibrating fire alarms, doorbell/door knock light, phone flasher and any other equipment that may be appropriate should be provided to deaf (and some hard of hearing) individuals.

AUDIOLOGY

An audiologist can identify hearing problems and helps in remediating these problems. A baseline hearing exam should be performed for individuals upon turning 55 years old and every 5 years thereafter, unless the audiologist has a specific reason to recommend a more frequent examination. Case managers should consider a referral if any of the following are present:

- frequent ear infections or upper respiratory disease,
- significant delay in speech and language,
- history indicating risk for hearing impairment.

COMMUNICATION THERAPY REFERRALS

Speech, language and communication specialists work with individuals encountering difficulty in verbal communication. This discipline works to verify possible language disorders, to describe language abilities and disabilities, to identify factors which may effect remediation and to plan remediation programs.

In the case of deaf, hard-of-hearing or hearing nonverbal individuals who use any signs or gestures referred for a communication evaluation, ask specifically for the specialist's knowledge of sign and gestural systems and ability to evaluate.

For further assistance in obtaining a sign language evaluation, ask the Departments Office of Deaf Services or the designated signing case manager in the regional office.

Refer when:

- 1. There is an apparent discrepancy between what the consumer has to say and his/her ability to say it.
- 2. Consumer has no functional communication system.
- 3. There is a question concerning need for an alternate/supplemental communication system (e.g., signing or communication board).
- 4. Speech is generally unintelligible.
- 5. There is a noticeable loss of communication skills.
- 6. Consumer's "use" of language is not appropriate or functional for communication.
- 7. You suspect a hearing loss.

DENTAL SERVICES

For many consumers, dental services are or are becoming available in local communities. Because Medicaid will not reimburse dental services for adults, a person's access to community dental services may be constrained by financial resources. Case managers are encouraged to pursue dental services within their social community prior to approaching the Department for use of the funded Dental Clinic.

The Dental Clinic services are free, with some exceptions. Dental services are provided at the Dental Clinic and at various outreach sites, as arranged by the regional offices. All people with developmental disabilities in Maine are eligible for services from the Dental Clinic. The Clinic does place a priority on serving people who require special expertise and/or anesthesiology services, and people who either do not have access to or do not have financial resources for community dental services.

In order to receive dental services through the Dental Clinic the person must:

- 1. Complete an application for dental services,
- 2. Have had a physical exam within the last year, and,
- 3. Make an appointment with the Clinic.

The role of the ISC in arranging dental services at the Dental Clinic varies according to the consumer's individual circumstances. If the consumer has access to family members or service providers who can arrange for dental needs to be met at the Dental Clinic, the ISC can simply describe the available services and monitor their delivery. In other instances, the ISC will be the person actually responsible for setting up appointments at the Dental Clinic and for arranging transportation

For consumers who are 62 or over, case managers should investigate the "Senior Dent" program.

Senior Dent is a program sponsored by the Maine Dental Association in cooperation with Area Agencies on Aging. It provides comprehensive dental care to low-income elderly at reduced rates. Maine residents who are 62 or over, have not dental benefits under Medicaid or private insurance plan, and have an income which qualifies them for the Low Cost Drug Program are eligible to enroll in Senior Dent. Eligible persons will receive a minimum 15 percent discount on all dental services from participating dentists.

EVALUATIONS AND CONSULTATIONS

Any number of variables will enter into making a request for an evaluation or consultation, including sound judgment and common sense. Age, history, current programming and other evaluations should all be taken into consideration. The interdisciplinary team must be a part of the referral process so that team members can offer information and receive feedback from the evaluation. Such an approach strengthens the cooperative effort and helps the team to function with other consumers, as well as the person being referred.

Frequency of evaluations should be determined by the needs of the consumer and the evaluator.

Evaluations for youngsters are frequently repeated every six months or yearly because of the child's rapid growth. Adults may need to be seen again every year or even every three years. The degree of intervention programmed by the specialist will also determine frequency of evaluation. Consultation should be done on an as needed basis with a note indicating the consultation has taken place. More frequent evaluations may be required for consumers in the waiver program and those subject to behavioral procedures.

The "why" of referral, evaluation and consultation seems obvious, but is often overlooked. The referring party should assist in not only gathering information for the specialist to use in the evaluation, but also to have in mind what is expected from the final report. A list of specific questions regarding the consumer would give the specialist or therapist a good starting point. The case worker might note that a certain problem showed up on a screening and ask why. Another problem might be evident, but strategy is the help being sought.

One important result of any evaluation is the final written report. This document should be received in a timely manner, and, if it isn't, then the referring person should work to expedite its release.

It is important for case managers to have a clear understanding of what types of intervention each discipline can provide. Understanding how each therapy can assist the client in his/her development will help the case worker make good judgments about when to refer and what questions to present to the therapist.

Support services staff are a valuable resource to the case worker and they should be consulted whenever there is a question about a consumer's progress or development. For example, changes in a consumer's behavior may signal a need for a psychological evaluation or minor modifications in a person's person centered plan. Consultation with the psychologist can help determine the appropriate course of action. Also, the role of the occupational therapist with adult consumers cannot be understated. Many adults with mental retardation have sensory problems that contribute to difficulty functioning in other areas. Consultation with the occupational therapist can help to identify and resolve these difficulties through appropriate person centered planning. Frequent consultation with

support services staff will insure timely and appropriate intervention in a consumer's program.

TIPS ON MAKING REFERRALS

- Provide the therapist with relevant background information about the consumer,
 i.e., history, previous evaluations from within that discipline or from a related discipline.
- Ask specific referral questions, preferably in writing, when requesting the evaluation or consult.
- Assure that necessary release forms are signed.
- Make the referral one to three months prior to the date report is needed, and make sure evaluator is aware of relevant timelines, i.e., date of person centered plan.
- If the evaluator requests that referral form is completed, assure that this is done.
- Attempt to assure that a person who is knowledgeable about the consumer is available to the therapist or clinician at the time of the evaluation/consult.
- Request a qualified interpreter (if needed) immediately after the appointment is scheduled. Assist the therapist in locating interpreters who work well with the consumer.

MONITORING OF PSYCHOTROPIC DRUGS

The case managers role with consumers who are taking psychotropic drugs is monitoring. For Community case managers the role will be to assure that the monitorinbg is taking place. This should be addressed in the persons plan and the person responsible for the monitoring identified. It is recommended that psychotropic drugs are evaluated every six months or as directed by a physician, with appropriate laboratory testing. The case manager should advocate for appropriate physical evaluation of the consumer before and during the psychotropic treatment.

Consent needs to be obtained from the client or guardian with information being provided regarding possible side effects.

When a consumer is placed on a new drug, his/her reaction to the drug should be closely monitored.. Family and support staff should observe the consumer for adverse physical and emotional reactions, as well as unintended behavioral changes. In some instances, the individual will have no reaction to the drug. In any of these cases, the case manager should question the use of a particular drug they should discuss concerns with the consumer and family and the consumers physician.

If there is a sudden, unexplained change in a consumer's behavior, a medication evaluation should be considered. Also, it should be noted that an individual who has a long history with one drug should be evaluated for irreversible side effects and possible drug alternatives. In addition, medication side effects or concerns about polypharmacy should be brought to the attending Physician.

Occasionally, the prescribing physician will be unwilling to make changes in a person's drug schedule. If the consumer's behavioral or emotional problems persist, the case manager should encourage second opinion to assure the most appropriate psychotropic medication is being utilized.

NUTRITIONIST

A nutritionist can assist in determining the nutritional status of an individual and any possible relationships to etiology or current problems, as well as to plan and implement a dietary change, if needed. They can consult with the consumer and family to shop, prepare, and serve meals that are indicated within the resources of the individual and family.

Indicators: metabolic disease, improper growth rate, obesity, low body weight, diagnosis of diabetis, sedentary life style, use of wheelchair, loss of teeth, swallowing disorder.

OBTAINING A SECOND OPINION

Second opinions can be extremely useful in helping the consumer and/or family make informed decisions about medical and other types of treatment. There are two situations where second opinions should <u>be considered:</u>

- 1. When elective surgery is recommended.
- 2. When a recommendation is made for "no code" or "no heroics" status for a consumer.

There are a number of other kinds of situations where a case manager should consider suggesting another opinion. Some examples of instances where another opinion should be considered are:

- When radical surgery is recommended, i.e., removal of limb, organ, etc.
- When conflicting medical opinions are given regarding a course of treatment,
- When consumer's medical problem is not resolved, i.e., uncontrolled seizures,
- When consumer has received psychotropic medication over extended period of time, with no attempt at reduction/alterations in regime.

NON-MEDICAL SECOND OPINION

There are also instances within other treatment modalities where second opinions can be useful. Some examples are:

- When there are conflicting opinions about whether a person should be considered to have mental retardation,
- Where there are conflicting recommendations from within a discipline or across disciplines, i.e., use of sign language vs. attempts at vocalization.

The standard that should be applied in deciding whether to seek a second opinion is the standard applied to the general population. The case manager should ask, "If I were this consumer, would I want another opinion?" It is equally important to examine the purpose of obtaining another opinion. The primary purpose should be to clarify a course of treatment or to assist in making a decision affecting a consumer. Second opinion should <u>not</u> be used to resolve unspecific concerns about physician or clinician competence.

PROCESS FOR OBTAINING A SECOND OPINION

In most instances, the case manager should approach the consumer's primary physician or clinician regarding the desire to pursue a second opinion about a particular issue. Getting agreement and cooperation will greatly enhance the chances of obtaining a meaningful and comprehensive second opinion. Extending the courtesy of discussing a possible second opinion and providing a clear rationale as to why it is desired will

hopefully ensure needed cooperation. The person being asked to give the second opinion also needs to be informed about the rationale and about whether the primary physician concurred or not with the solicitation of a second opinion.

Once the second opinion has been obtained, the case manager should assure that there is clear documentation in the consumer's record about the outcome and course of treatment. If for any reason the case worker is unable to obtain a second opinion, or continues to be dissatisfied with the consumer's progress; the case worker should bring it to the attention of their Supervisor.

OCCUPATIONAL THERAPY

Occupational therapy (OT) is concerned with stimulating independence and enhancing productive function. Occupational therapy concentrates on the areas of motor, perceptual motor, and personal/social skills. Indicators: Problems in reaching and grasping, poor self-help skills, difficulty in relating body to space.

An occupational therapist can useful in assessing and/or dealing with the following:

- 1. Balance problems not associated with skeletal or orthopedic problems.
- 2. Upper extremity problems including:
 - Strength, range of motion and/or deformities,
 - Fine motor coordination,
 - Asymmetry (not attributed to dominance).
- 3. Self-help skills.
- 4. Prevocational skills.
- 5. Sensory problems:
 - Eye movement,
 - Eye/hand/foot coordination,
 - Aversion to or lack of awareness of touch,
 - Fear of movement/too much movement.
- 6. Tendency to not use both hands or arms for bimanual tasks.
- 7. Motor planning difficulty (problems learning new motor tasks).
- 8. Need for adaptive equipment or methods to decrease deformity or increase function for;
 - Vocational or prevocational tasks,
 - Cooking,
 - Hygiene,
 - Dressing
 - Other daily living skills.
- 9. Visual/perceptual skills,
 - Form and space perception,
 - Figure/ground perception, etc.
- 10. Social Skills
- 11. An occupational therapist can also help in determining learning style.

PHYSICAL THERAPY

Physical therapy (PT) may be appropriate for persons who have problems with posture and locomotion. Posture is the ability to assume and/or maintain the body, or segment of, in a specific position. Locomotion is the ability to move from place to place. Indicators: poor postural reflexes, disorders of tone, movement, strength, balance, or coordination.

A physical therapist can be useful in assisting and dealing with the following:

- 1. Posture or general skeletal alignment involving spine and limbs.
- 2. Range of motion/joint flexibility/deformities such as severe flat feet, arm and leg joint tightness.
- 3. Gait (walking) or other means of mobility (creeping, wheelchair use).
- 4. Need for adaptive equipment to assist in safety, accessibility, positioning, or mobility.
- 5. Orthotic (braces) or prosthetic (artificial limbs) devices for back or legs.
- 6. Selection of proper shoes, shoe inserts and lifts.
- 7. Problems with balance equilibrium.
- 8. Coordination.
- 9. Pain related to movement.
- 10. Strength/endurance/
- 11. Muscle tone too much (spasticity) or too little (hypotonicity).
- 12. Gross motor skills.
- 13. Body mechanics for clients or care givers.
- 14. Transfer techniques.

REFERRALS TO PSYCHOLOGIST COMMON REFERRAL QUESTIONS/REASONS FOR REFERRAL

1. Routine Psychological (Evaluation/Review)

(All referrals for therapeutic services must have a written physician's order to claim insurance)

Ask the psychologist to provide you with information relevant to areas that will be addressed in the Person Centered Plan or next case review. Specific areas in which one might request information are: consumer strengths, needs, long-term goals, priority short-term goals, types of placements which would meet needs, additional services may need, etc. Also, ask psychologist to address specific area you know will be discussed at the Person Centered Plan or case review (i.e., guardianship, behavior problems). If the psychologist has been seeing the consumer in therapy, but is unable to attend the Person Centered Plan, she/he may want to send information relevant to the Person Centered Plan.

2. Evaluation for Eligibility for MR Services

Send psychologist a copy of MR's eligibility guidelines so that she/he knows that both a low IQ (70) and problems in adaptive functioning are required for MR eligibility.

3. Guardianship

Ask the psychologist to assess the need for guardianship and/or conservatorship.

4. <u>Psychological Evaluation to apply for and/or determine eligibility for another</u> government agency (i.e., Vocational Rehabilitation, SSI).

Each agency has its own criteria, but it will help to get relevant information if you:

- a. Tell the psychologist to which agencies the consumer is applying,
- b. Ask psychologist to include a diagnosis in their report,
- c. Ask psychologist questions relevant to the specific agency.

Vocational Rehabilitation requires the consumer to be handicapped, but to have vocational potential. Ask the psychologist to specify the client's handicapping conditions, including offering a diagnosis. Also, ask the psychologist to discuss the consumer's vocational potential and to make recommendations for how to develop this potential (i.e., recommended services). Incidentally, employment in a sheltered workshop or success as a homemaker are considered acceptable goals by Vocational Rehabilitation in considering the client's "vocational potential".

5. Referral for evaluation of emotional/behavioral problems

There are a variety of reasons you might refer for evaluation in this area. Please specify your reason(s) for referral and the types of assistance you want/questions you want addressed. Examples of possible needs in this are as follows:

- Request for recommendations for behavior modification program. Be sure to specify types of consumer behaviors which are problematic and describe any interventions which have been tried so far.
- Evaluation for consumer suitability for psychotherapy. Tell psychologist if you want them to consider doing psychotherapy with this consumer themselves, or they may not realize this is a possibility. Also, ask for recommendations for how home and program can help with adjustment problems.

WORKING WITH PHYSICIANS IN SUPPORT OF PEOPLE WITH DISABILITIES

The medical profession has historically played an important role in the early diagnosis of mental retardation and related developmental disabilities. In recent years, research has greatly expanded our knowledge as to the myriad causes of mental retardation. Advances in the field of genetics have allowed the medical profession to extend its diagnostic capabilities into the prenatal period.

In most cases, the physician is the first professional consulted by a family when developmental problems are suspected during childhood. Since regular postnatal care is routine in our society, we can expect that developmental problems will be identified during the early stages of growth. In many cases, physicians are in the position of confirming problems already suspected by parents. In some instances, the physician may detect developmental problems before the child's parents have become aware of them.

Our society ascribes high status and great authority to the physician. As such, the content of the physician's informing interview with the parents of a child with a developmental delay can affect treatment of the child for years to come. Historically many parents sought institutional placement for their children with disabilities based on their physician's advice. Others have delayed seeking assistance because they were told that their child would "grow out of it".

It is very important that the case manager develop a positive, collaborative relationship with the consumer's physician. The case manager should keep the physician informed of his/her activities surrounding the consumer and attempt to involve the physician in the developmental assessment.

The Physician's knowledge and perception of the individual are important components in a comprehensive assessment and every effort to include the physician as an active team member should be made. This is particularly true in the case of consumers with severe and multiple handicaps. Seizure control, orthopedic needs, and medical stabilization rest squarely with the physician. Often, active treatment and programming cannot begin until these needs are met.

The medical profession has professional boundaries, which are clearly defined and closely guarded. The case manager must be sensitive to this dynamic in order to foster a productive working relationship. In consulting with a consumer's physician, the case manager should avoid diagnosing the consumer or recommending specific modes of treatment. In essence, problem identification is best done in descriptive rather than analytical terms. If working with consumers, the case manager should also encourage the consumer's parents to be informed consumers of medical care if the consumer requests this input or the parent(s) are the guardian. The case manager's role is to assist the consumer in the decision-making process by providing information and utilizing appropriate resources.

Case management with medically needy, developmentally delayed consumers will be easier and more productive with the active and informed cooperation of the physician. As such, advocacy in the area of medical care should be balanced by an awareness of, and sensitivity to, the unique nature of the physician's relationship to the consumer. The case manager should seek to share with the physician the total picture of the consumer's assets and needs that is gained from the case management perspective. In doing so, the case manager can assist the physician to coordinate his or her activities with the overall treatment plan for the consumer.